

6
00-08977

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

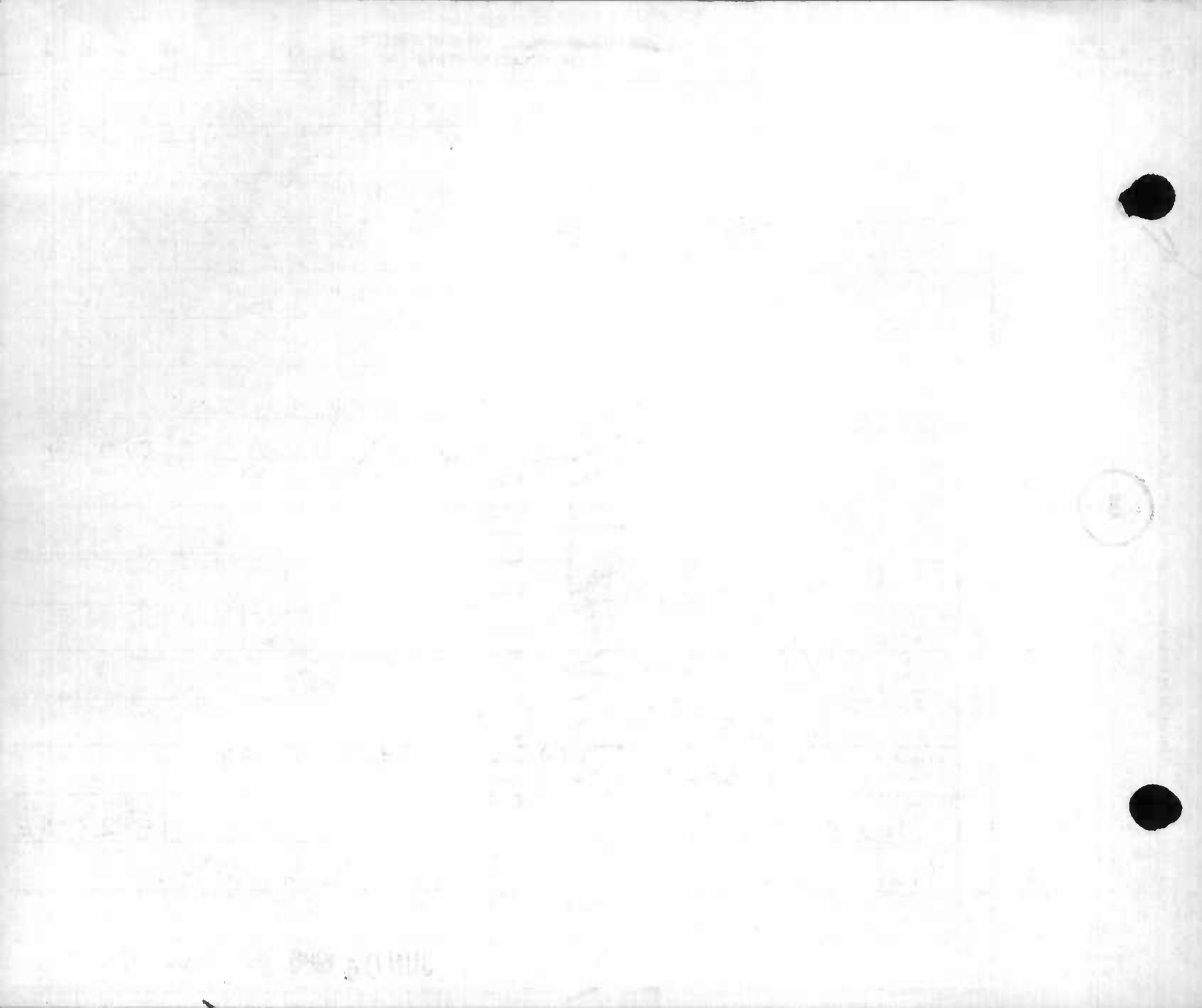
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 48, there is any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 4 4 2 1	
1. FOR STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELSON S. BAILEY			2a. DATE OF DEATH MONTH DAY YEAR 5 24 86		2b. HOUR 8:15 P _M
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 14 09	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		6. AGE (IN YEARS LAST BIRTHDAY) YRS 77	
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 302 Walnut St.		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Seafood			
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun	
14. FATHER'S NAME FIRST MIDDLE LAST John N. Bailey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-12-1656		17. INFORMANT ADDRESS Mrs. Margaret Bailey - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF b) <u>Hx of smoking</u> DUE TO, OR AS A CONSEQUENCE OF c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hx of smoking</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Oct 84</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10</u> 19 <u>84</u> to <u>5-24</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5-23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <u>Neil Taylor</u> MO		DEGREE		22c. DATE SIGNED 5-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MO		22e. ADDRESS Rising Sun, Md.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-25-86		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
25a. DATE REC'D. BY REGISTRAR JUN 04 1986					



00-08229

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

14422

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hayes H. Biddle			2a. DATE OF DEATH MONTH DAY YEAR May 29, 1986		2b. HOUR 1750 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 1, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North East, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesmanager		12b. KIND OF BUSINESS OR INDUSTRY Ind.	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.			13c. COUNTY Cecil		13d. CITY OR TOWN North East		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 47 McKinney Town Rd. 21901	
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14. FATHER'S NAME FIRST MIDDLE LAST Ernest Biddle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah Alexander		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 273-09-4292		17. INFORMANT ADDRESS Georgia M. Biddle North East, Md. 21901	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sepsis - Pneumonia and urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gleablastoma multifocum of right parietal lobe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>slight pressure to lung area</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 2 weeks</u> <u>months</u>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

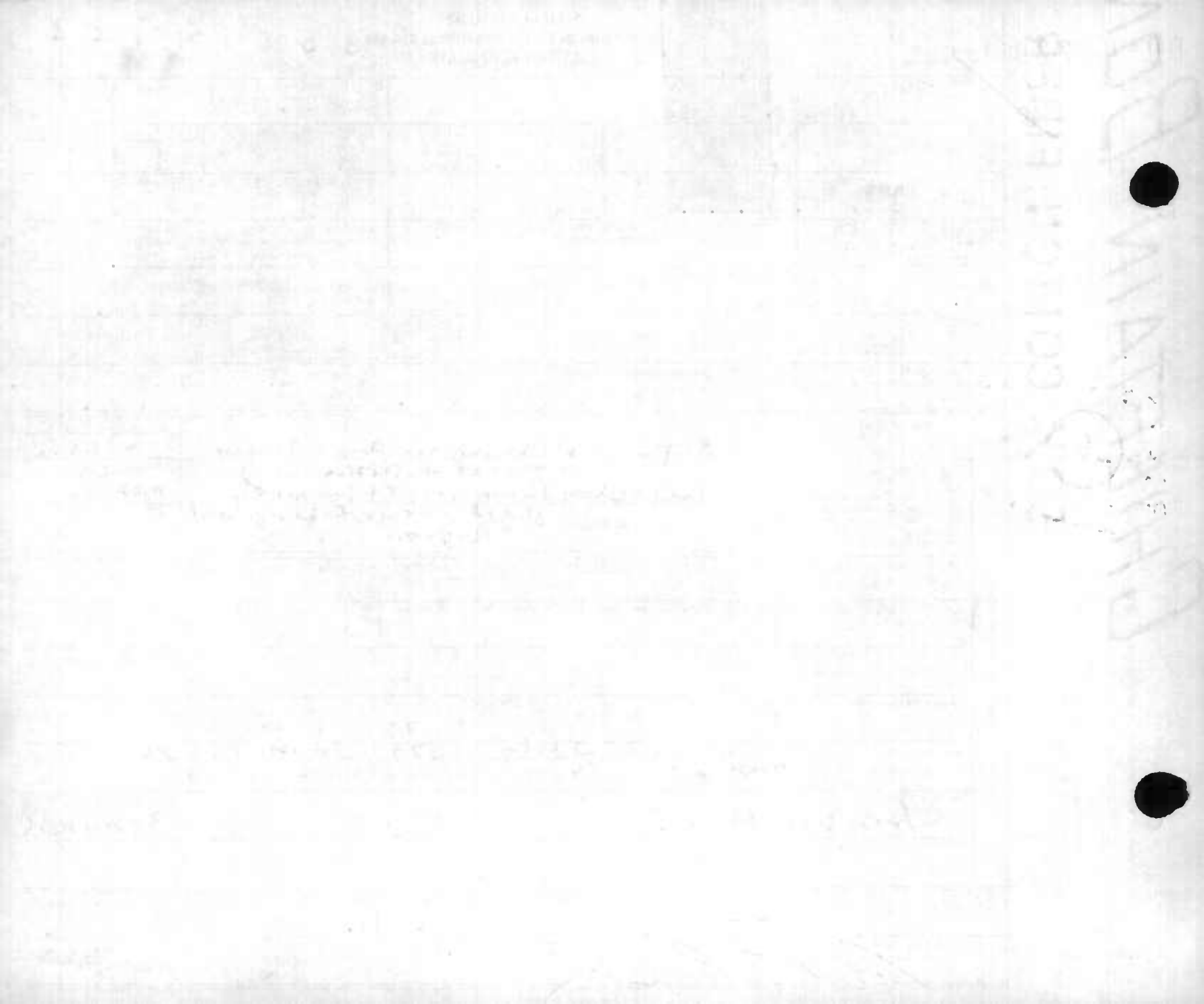
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1977</u> to <u>May 29, 1986</u> , that (I) (we) last saw the deceased alive on <u>May 29, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles H. Biddle</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 30 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-86		23c. NAME OF CEMETERY OR CREMATORY North East Meth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.	
24. FUNERAL HOME NAME Funeral Home North East, Md.				25a. DATE REC'D. BY REGISTRAR JUN 2 1986		25b. REGISTRAR'S SIGNATURE <u>John D. Anderson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 22 is marked, the medical examiner must be notified at once.

BP



00-06593

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

14423

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

SARAH

N.

BRYAN

2a. DATE OF DEATH MONTH DAY YEAR
MAY 11, 1986

2b. HOUR
M

3 SEX

FEMALE

4 RACE

WHITE

5. DATE OF BIRTH

MONTH DAY YEAR
AUGUST 23, 1910

6 AGE (IN YEARS LAST BIRTHDAY)

75

YRS

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Cecil County

MD.

10 CITY OR TOWN OF DEATH

Elkton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Union Hospital of Cecil County

12a. USUAL OCCUPATION

Teacher

12b. KIND OF BUSINESS OR INDUSTRY

School-Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Cecil

13c. CITY OR TOWN

Elkton

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

604 Bridge St., 21921

14 FATHER'S NAME

ELI

MIDDLE

LAST

BOWER

15 MOTHER'S MAIDEN NAME

AGNES

MIDDLE

LAST

NINE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

None

16b. SOCIAL SECURITY NO.

17 INFORMANT

ADDRESS

(IF YES, GIVE WAR OR DATES)

212 38 4378

Mrs. Marlene B. Cooke, Victoria, Texas

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cerebral Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

Cerebral Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

Coronary Artery Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/2/63, 19, to 5/11, 1986, that (we) last

saw the deceased alive on 4/24, 1986, and that in (my/our) opinion death occurred on the date and hour and from the causes stated

above, (I/we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING

MEDICAL

STAFF

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

JOSEPH G. LANZI,

M.D.

22e. ADDRESS

721 Bridge Street, Elkton, Maryland 21921

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

5/16/86

23c. NAME OF CEMETERY OR CREMATORY

Gilpin Manor Mem. Park

23d. LOCATION

Elkton

Cecil

Md.

24 FUNERAL DIRECTOR

HICKS HOME FOR FUNERALS,

Elkton, Md.

25a. DATE REC'D. BY REGISTRAR

MAY 15 1986

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

MEDICAL CERTIFICATION

BP

000000-00

NOV 10 1955



00-08978

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14424

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE OF ESTIMATED DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
STEVEN RAY CHADWICK		Male		white		Feb 21 1986		4 YRS. 4 MONTHS 0 DAYS 0 HOURS 0 MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Eikton md.		U.S.A.				Cecil County		Port Deposit	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. CITY OR TOWN	
406 Susquehanna River Rd.						md		Cecil	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Charles		Wendy		no		none		Charles Chadwick	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
PART I DEATH WAS CAUSED BY:						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
IMMEDIATE CAUSE (a) <u>Sudden infant death syndrome</u>								P.M. 19	
DUE TO, OR AS A CONSEQUENCE OF								21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
(b) _____								21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF								21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
(c) _____								21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
MEDICAL CERTIFICATION								22b. DATE 5/31/86	
								22c. NAME OF CEMETERY OR CREMATORY Eikton Cemetery	
								22d. LOCATION CITY OR TOWN COUNTY STATE Eikton Cecil md.	
								22e. DATE REC'D. BY REGISTRAR 5-28-86	
								22f. REGISTRAR'S SIGNATURE	
								22g. DATE 5-28-86	
								22h. REGISTRAR'S SIGNATURE	
								22i. DATE 5-28-86	
								22j. REGISTRAR'S SIGNATURE	
								22k. DATE 5-28-86	
								22l. REGISTRAR'S SIGNATURE	
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								22dt. REGISTRAR'S SIGNATURE	
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								22dv. REGISTRAR'S SIGNATURE	
								22dw. DATE 5-28-86	
								22dx. REGISTRAR'S SIGNATURE	
								22dy. DATE 5-28-86	
								22dz. REGISTRAR'S SIGNATURE	
								22ea. DATE 5-28-86	
								22eb. REGISTRAR'S SIGNATURE	
								22ec. DATE 5-28-86	
								22ed. REGISTRAR'S SIGNATURE	
								22ee. DATE 5-28-86	
								22ef. REGISTRAR'S SIGNATURE	
								22eg. DATE 5-28-86	
								22eh. REGISTRAR'S SIGNATURE	
								22ei. DATE 5-28-86	
								22ej. REGISTRAR'S SIGNATURE	
								22ek. DATE 5-28-86	
								22el. REGISTRAR'S SIGNATURE	
								22em. DATE 5-28-86	
								22en. REGISTRAR'S SIGNATURE	
								22eo. DATE 5-28-86	
								22ep. REGISTRAR'S SIGNATURE	
								22eq. DATE 5-28-86	
								22er. REGISTRAR'S SIGNATURE	
								22es. DATE 5-28-86	
								22et. REGISTRAR'S SIGNATURE	
								22eu. DATE 5-28-86	
								22ev. REGISTRAR'S SIGNATURE	
								22ew. DATE 5-28-86	
								22ex. REGISTRAR'S SIGNATURE	
								22ey. DATE 5-28-86	
								22ez. REGISTRAR'S SIGNATURE	
								22fa. DATE 5-28-86	
								22fb. REGISTRAR'S SIGNATURE	
								22fc. DATE 5-28-86	
								22fd. REGISTRAR'S SIGNATURE	
								22fe. DATE 5-28-86	
								22ff. REGISTRAR'S SIGNATURE	
								22fg. DATE 5-28-86	
								22fh. REGISTRAR'S SIGNATURE	
								22fi. DATE 5-28-86	
								22fj. REGISTRAR'S SIGNATURE	
								22fk. DATE 5-28-86	
								22fl. REGISTRAR'S SIGNATURE	
								22fm. DATE 5-28-86	
								22fn. REGISTRAR'S SIGNATURE	
								22fo. DATE 5-28-86	
								22fp. REGISTRAR'S SIGNATURE	
								22fq. DATE 5-28-86	
								22fr. REGISTRAR'S SIGNATURE	
								22fs. DATE 5-28-86	

Filter no. 12
T-101

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 N. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 4 4 2 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert		MIDDLE Harry		LAST Childs		2a. DATE KNOWN OF DEATH		ESTI- MATED		X 5 31 1986		MONTH DAY YEAR		2b. HOUR M							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 3, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 5 31 1986		2d. HOUR M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.											
10. CITY OR TOWN OF DEATH Perryville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19 River Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personnel Mgr.				12b. KIND OF BUSINESS OR INDUSTRY Post Office											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Penna.				13b. COUNTY Lancaster				13c. CITY OR TOWN Millersville											
14. FATHER'S NAME FIRST Harry				MIDDLE L.				LAST Childs				15. MOTHER'S MAIDEN NAME FIRST Julia				MIDDLE (NMI)				LAST Laudenberger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II				17. INFORMANT Robert H. Childs, Jr.				ADDRESS Millersville, Pa. 300 Herr Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE J. S. [Signature]				M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 5-31-86											
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vitale MD				ADDRESS Union Hospital, Elkton MD 21922																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 5, 1986				23c. NAME OF CEMETERY OR CREMATORY Millersville Menn. Cem. Millersville, Lancaster Pa.				23d. LOCATION CITY OR TOWN COUNTY STATE											
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.				25a. DATE REC'D. BY REGISTRAR JUN 4 1986				25b. REGISTRAR'S SIGNATURE [Signature]															

Robert H. Childs
Male White
15
(Cell 1001)

1A River Road

Cor. and West of 10th St.



x

x

2-3-10

1001 (Cell 1001) 2-3-10

00-06591

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7. REG. NO.				
1. DECEASED NAME (Type or Print)					2a. DATE OF DEATH			2b. HOUR	
FIRST MIDDLE LAST Horace W. Cornell					MONTH DAY YEAR May 10, 1986			9:00 A.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		MONTH DAY YEAR Nov. 4, 1923		62 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				Cecil MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
North East		5 Roney Ave.				Self employed		Carp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE			
Md.		Cecil		North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 756 Bethel Church Rd. 21901			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Charles Cornell					Mary Elizabeth Singleton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		217-18-5749		Olive Cornell		756 Bethel Church Rd. North East, Md. 21901			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac and Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive Ca of the lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple metastasis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cardiac Arrhythmia = A S C V D</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>Sep 26</u> , 19 <u>76</u> , to <u>5-10-</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5-8-</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Luis M. Cuza</u>		M.D.						5-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Luis M. Cuza, M.D.					322 E. Cecil Ave. North East Md 21901				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5-13-86		Bethel Cem.		North East Cecil Md.			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Crouch Funeral Home North East, Md.					MAY 15 1986		<u>John Davidson</u>		



00-06107

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

14427

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DALE NMN COSNER			2a. DATE OF DEATH MONTH DAY YEAR MAY 6 1986		2b. HOUR 4:00A M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11-01-12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coalminer		12b. KIND OF BUSINESS OR INDUSTRY B & O R.R.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE /MD 13b. COUNTY A.A.			13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5509 Chatham Rd. 21225
14. FATHER'S NAME FIRST MIDDLE LAST Luther Soliman Cosner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Statcia Moon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 232 21 1193		17. INFORMANT ADDRESS Glen Burnie, MD 21061 David D. Cosner 8108 Phirme Rd. E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 25</u> , 19 <u>86</u> , to <u>MAY 6</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>MAY 6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Christopher M. Berchermann</i> MD 22b. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER M. BERCHELMANN				22c. DATE SIGNED 22c. ADDRESS VA MEDICAL CENTER PERRY POINT MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-9-86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.	
24. FUNERAL DIRECTOR NAME MC CULLY FUNERAL HOME		24b. ADDRESS 237 E. Patapsco Ave. 21225 BALTIMORE MD		25a. DATE REC'D. BY REGISTRAR MAY 9 1986	
		25b. REGISTRAR'S SIGNATURE <i>Charles D. Henderson</i>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
NOV 10 1963

NOV 10 1963



20
0-08647

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALFRED WILSON DARLOW						2a. DATE OF DEATH MONTH DAY YEAR MAY 26, 1986		2b. HOUR 8:25 AM	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR NOV. 11, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.			
10. CITY OR TOWN OF DEATH EARLEVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROSE HILL FARM GROVE NECK				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY ACCOUNTING	
13a. STATE MARYLAND				13b. COUNTY CECIL		13c. CITY OR TOWN EARLEVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED M. DARLOW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAURA WILSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW 11 059-18-9714		17. INFORMANT ADDRESS ALEX BASIN (atty) TOWN, MD 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>misdiagnosis (circumstances) of the colon and polyps</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 mo	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> , 19 <u>86</u> , to <u>5/22</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/22</u> , 19 <u>86</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kenneth Lewis MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS, M.D.				22e. ADDRESS UNION HOSPITAL OF CECIL COUNTY ELKTON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/30/86		23c. NAME OF CEMETERY OR CREMATORY FOREST LAWN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BUFFALO, ERIE, NEW YORK			
24. FUNERAL DIRECTOR NAME FELLOWS F.H. BOX 270 MILLINGTON, MD 21651				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John Davidson			

00-09180

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 4 2 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JERRY R. DEAVER		2a. DATE OF DEATH MONTH DAY YEAR 05-21-86		2b. HOUR am. 03:48 _M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 9, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD.	
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES REPRESENTATIVE		12b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE
13a. STATE PENNSYLVANIA		13b. COUNTY CHESTER	13c. CITY OR TOWN AVONDALE	13d. STREET ADDRESS P.O. Box 132 99999	
14. FATHER'S NAME FIRST MIDDLE LAST VERNON DEAVER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NINA SCHULER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO. 207-26-4533		17. INFORMANT ADDRESS P. JEANNE DEAVER P.O. Box 132, AVONDALE, PA. 19311			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL INFARCTION (b) _____ DUE TO, OR AS A CONSEQUENCE OF CVA; ISCHEMIC ASCVD (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GENERALIZED ATHEROSCLEROSIS; RECENT MYOCARDIAL INFARCTION, CVA

19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I. OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —	21f. LOCATION STREET CITY OR TOWN COUNTY STATE —	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on May 21, 1986, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Joseph F. Klein	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/21/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH F. KLEIN MD		22e. ADDRESS PO BOX 189 WEST GROVE PA 19390	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE MAY 24, 1986	23c. NAME OF CEMETERY OR CREMATORY R.A. FERRIS COMPANY	23d. LOCATION CITY OR TOWN COUNTY STATE WEST CHESTER CHESTER PA.
24. FUNERAL DIRECTOR NAME ADDRESS Richard L. Goodie Rising Sun, Md.		25a. DATE REC'D. BY REGISTRAR 05-1986 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-05852

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner will be notified on page 3.

BP

DHMH - 16 50M 4/83
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 3 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH NMN DeSHANE			2a. DATE OF DEATH MONTH DAY YEAR MAY 1, 1986			2b. HOUR 0245 M			
3. SEX female		4. RACE cauc.		5. DATE OF BIRTH MONTH DAY YEAR Apr. 21, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 97		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.			
10. CITY OR TOWN OF DEATH EKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSP. OF CECIL CO.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY KENT		13c. CITY OR TOWN GALENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BOX 96 Rt 313 East 21635	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JONES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE RASIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-56-0844		17. INFORMANT ADDRESS ANNA HOPKINS BOX 96 GALENA MD 21635					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the physician) attended the deceased from June , 19 84 , to 1 May 86 , 19____, that (I) (we) last saw the deceased alive on 1 May 86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.									
22b. SIGNATURE Wallace Obenshain MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALLACE OBENSHAIN MD				22e. ADDRESS CECIL-KENT HEALTH SERVICES CECILTON					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/4/86		23c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CHES. CITY, CECIL, MD			
24. FUNERAL DIRECTOR NAME FELLOWS F.H. BOX 270 MILLINGTON, MD 21104				25a. DATE REC'D. BY REGISTRAR MAY 07 1986		25b. REGISTRAR'S SIGNATURE G. Davidson			

00-07526

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14431

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Robert E. Dougherty				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 17 YEAR 1986				7b. HOUR M	
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Feb. DAY 13 YEAR 1944	6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 5 17 1986		7d. HOUR 1:33 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) In transit to the hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor - DuPont		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Delaware		13b. COUNTY New Castle	13c. CITY OR TOWN New Castle	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1025 Bear Road		9999	
14. FATHER'S NAME FIRST Robert MIDDLE Edward LAST Dougherty, Sr.				15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 222-26-5622		17. INFORMANT Alberta J. Dougherty ADDRESS 1025 Bear Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes Mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE J. C. Gonzalez-Vital			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			DATE SIGNED 5-17-86			
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vital MD			ADDRESS Union Hospital, Elkton MD 21921						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 21, 1986		23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		23d. LOCATION CITY OR TOWN Wilmington COUNTY New Castle STATE Delaware			
24. FUNERAL DIRECTOR NAME Robert T. Jones ADDRESS 122 W. Main Newark, DE 19711				25a. DATE REC'D. BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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00-08606

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

Filipponi, C-
144321- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Christine S. Filipponi			2a. DATE OF DEATH MONTH MAY DAY 22 YEAR 1986			2b. HOUR M			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH April DAY 7 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Long Island NY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAURELWOOD Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE md.		13b. COUNTY Cecil		13c. CITY OR TOWN ELKTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 73 MURRAY Rd. 21921	
14. FATHER'S NAME FIRST SICO MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST Bernedette MIDDLE LATTERIO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. no info		17. INFORMANT Lucille Dow ADDRESS P.O. Box 1 Newark, De.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DISEASE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
									Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a DIABETES MELLITUS, IDIOPATHIC THROMBOCYTOPENIC PURPURA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1 DEC 19 83 to 12 MAY 19 86 that (I) (we) last saw the deceased alive on 21 MAY 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/22/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Linwood Blum, MD					22e. ADDRESS 721 THREE STREET ELKTON, MD 21921				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/24/86		23c. NAME OF CEMETERY OR CREMATORY All Saints Cem.		23d. LOCATION CITY OR TOWN Wilmington COUNTY New Castle STATE De		
24. FUNERAL DIRECTOR NAME Edna M. McLean ADDRESS Bee Funeral Home 259 E. Main St Elkton					25a. DATE REC'D. BY REGISTRAR JUL 10 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please file this with the local health department. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, send the medical examiner.

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

00-07159

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 3 3

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA G Gough			2a. DATE OF DEATH MONTH DAY YEAR 5 19 86			2b. HOUR 3 40 P M	
3. SEX FEMALE		4. RACE C 1		5. DATE OF BIRTH MONTH DAY YEAR 12 1 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Rising Sun, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CALVERT Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERICAL	
12b. KIND OF BUSINESS OR INDUSTRY APG		13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 115 West Wood Rd 21911		14. FATHER'S NAME FIRST MIDDLE LAST Andrew Fogus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Cochran	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-12-6522		17. INFORMANT Cecil Gough, 115 West Wood Rd., Rising Sun		ADDRESS 21911	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>(Smoker)</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>86</u> , to <u>5-19-86</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5-19</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Neil Taylor MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-19-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD		22e. ADDRESS Rising Sun, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-23-86		23c. NAME OF CEMETERY OR CREMATORY West Nottingham		23d. LOCATION CITY OR TOWN COUNTY STATE Cecil. MD	
24. FUNERAL DIRECTOR NAME Richard A. Gordie ADDRESS 2400 Rising Sun, Md.				25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE John Gordon	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP _____

00-07586

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM F. GRESHAM					2a. DATE OF DEATH MONTH DAY YEAR May 15, 1986			2b. HOUR 1:25pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 4, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Manager		12b. KIND OF BUSINESS OR INDUSTRY Yellow Cab Co.	
13a. STATE South Carolina		13b. COUNTY Greenville		13c. CITY OR TOWN Simpsonville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Gresham Road Box 348, Rt. 5 29681	
14. FATHER'S NAME FIRST MIDDLE LAST James Willis Gresham					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Dillard				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW II 579-10-1248		17. INFORMANT ADDRESS 1106 Bay Ridge Ave., Annapolis, Md. Mr. Larry Gresham (Son) 21403-2902					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 14, 1986 to May 15, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check this box.)									
22b. SIGNATURE Melecia Santos, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5-15-86	
22d. PHYSICIAN'S NAME (PRINT) Melecia Santos, M.D.					22e. ADDRESS VA Medical Center, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Antioch Presbyterian Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Spartansburg Co., Carolina			
24. FUNERAL DIRECTOR Mackey Mortuary 311 Century Drive, Greenville, SC 29602					25. DATE REC'D. BY REGISTRAR MAY 23 1986				
25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>									

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DHMH 16 FORM 7/84
(VRA 4, 4)

000-01200



2021 05 YAM

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 4 4 3 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Henry Riley Hanes				2a. DATE OF DEATH MONTH DAY YEAR May 11, 1986				2b. HOUR 9:05PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 5, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perry Point Veterans Adm. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. STATE Maryland				13b. CITY OR TOWN Prince Geo.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 4225 30th Street 20712			
14. FATHER'S NAME FIRST MIDDLE LAST Bennie G. Hanes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Berge							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ww-2		17. INFORMANT 8716 Racetrack Road Lela Schneider, Bowie, Maryland 20715					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest secondary to DUE TO, OR AS A CONSEQUENCE OF (b) Laryngeal cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (s)he (this hospital) attended the deceased from 4-29-1986 to 5-11-86, that (s)he (we) last saw the deceased alive on 5-11-1986, and that (s)he (our) opinion death occurred on the date and hour and from the causes stated above. (s)he (we) (did) (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER M. BERCHELMANN, M.D.				22c. ADDRESS VAMC, Perry Point, Maryland				22d. DATE SIGNED 5-11-86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-15-86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland			
24. FUNERAL DIRECTOR NAME Francis Gaschs & Sons						4739 Baltimore Ave., ADDRESS Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR MAY 13 1986			
25b. REGISTRAR'S SIGNATURE											

1938

NO. 100, 800

ONE

WATER



0-06230

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Pearl

Virginia

Harmer

2a. DATE KNOWN OF DEATH
ESTIMATED ☒ MONTH DAY YEAR
5 6 1986

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

2d. HOUR

Female

White

6 13 1913

72 YRS.

MONTHS DAYS HOURS MIN.

5 6 1986

1030 A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MARYLAND

U.S.A.

Cecil County

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

Elkton

252 East Main Street

HOMEMAKER

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

21921

MARYLAND

CECIL

ELKTON

YES ☒ NO ☐

252 E. MAIN ST.

14. FATHER'S NAME

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

MIDDLE

LAST

JEREMIAH

REED

MARY

BELLE

COLEMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

NO

219 16 9889

Donald C. Harmer, Jr. Elkton, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Atherosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

P.M. 19

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED

5-6-86

EXAMINER'S NAME

Juan C Gonzalez-Vitali MD

ADDRESS

Union Hospital Elkton MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY

STATE

BURIAL

5/9/86

Mt. Zion Methodist Cem. Fairfield, Lancaster Pa.

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Micks Home for Funerals

Elkton, Md.

MAY 12 1986

00-07820

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6
REG. NO.

1 4 4 3 7

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LESTER (NMI) HESS			2a. DATE OF DEATH MONTH DAY YEAR May 27, 1986		2b. HOUR 3:15P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 11, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurant Owner		12b. KIND OF BUSINESS OR INDUSTRY Self-employed
13a. STATE Md.			13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Hess			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Owens		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 227-24-6860		17. INFORMANT ADDRESS Gladys S. Hess, 410 Maloney Rd, Elkton 21921	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Carcinoma of lung, advanced**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) **Cardiopulmonary arrest**
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 18 19 86 to May 27 19 86 , the deceased above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>J. R. Garcia</i> DEGREE J. R. GARCIA, M.D.			22c. DATE SIGNED 5-27-86
22e. ADDRESS VA Medical Center, Perry Point, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 30, 1986	23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md.
24. FUNERAL DIRECTOR <i>Patterson & Son</i> Patterson & Son, Perryville, MD 21903		25a. DATE REC'D. BY REGISTRAR MAY 28 1986	
		25b. REGISTRAR'S SIGNATURE <i>Jana Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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REBIS INCLIP CO

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1000



1000

00-07345

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 3 8
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROBERT S. JACKSON			2a. DATE OF DEATH MONTH DAY YEAR May 21, 1986		2b. HOUR 2:58pm
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD	
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. Box 22 21014	
14. FATHER'S NAME FIRST MIDDLE LAST Ellis Jackson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Mary Belle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1923-26 228-07-1833		17. INFORMANT ADDRESS V.A.M.C. Records, Perry Point, Maryland.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

- 0 -

7 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Brain Tumor - most probable Chromophobe Adenoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 22 , 19 86 , to May 21 , 19 86 . XXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if I was (we) (is) (are) not view the body after death.			
22b. SIGNATURE John Lonergan		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 5-21-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LONERGAN, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 23, 1986	23c. NAME OF CEMETERY OR CREMATORY Quantico National Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Triangle, Prince William, Va.
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland.		25a. DATE REC'D. BY REGISTRAR MAY 22 1986	25b. REGISTRAR'S SIGNATURE Jana Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or other final disposition.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 3 9
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward C. Jacobs			2a. DATE OF DEATH MONTH DAY YEAR May 3, 1986			2b. HOUR 10:30PM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.				
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perry Point Vet. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired-crane oper.		12b. KIND OF BUSINESS OR INDUSTRY Armco Steel		
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Jacobs					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Walker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes					16b. SOCIAL SECURITY NO. 12/12/23 212 05 7642		17. INFORMANT ADDRESS Rose Jacobs, 3227 Lawnview Ave 21213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Presumed septic shock DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from 9-10-85, 19-85, to May 3, 19-86, that (X) (we) lost saw the deceased alive on May 3, 19-86, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
27b. SIGNATURE x Michael Delahunt						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		27c. DATE SIGNED 5-3-86		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL DELAHUNT, M.D.						27e. ADDRESS VA Medical Center, Perry Point, MD 21902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/6/86		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR ZANNINO FUNERAL HOME, Baltimore, MD. 21224						25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE June Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

10-02-10

1910-1911

1910-1911

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00-06083

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614440

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Otto W. Jensen			2a. DATE OF DEATH MONTH DAY YEAR May 5, 1986			2b. HOUR 7:15P M			
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 29 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Denmark		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V. A. Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military Service		12b. KIND OF BUSINESS OR INDUSTRY	
13a. COUNTY Maryland			13b. CITY OR TOWN Cecil Elkton		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 21921 Oldfield Point Rd, ELKTON		
14. FATHER'S NAME FIRST MIDDLE LAST Peter Jensen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sofie Pedersen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 2/18/223/31/5279 46 1571		17. INFORMANT ADDRESS Frederick J. Jensen, 201 Landing Lane Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from XXXXXX Nov. 8 19 85 to May 5 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 5 19 86 , and that in XXX (our) opinion death occurred on the date and hour and from the causes stated above. (Type) (Initial) (Signature) (Date) (Initial) (Signature) (Date) (Initial) (Signature) (Date)									
22b. SIGNATURE Christopher M. Berchelmann M.D.					DEGREE M.D.			22c. DATE SIGNED 5-5-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher M. Berchelmann, M.D.					22e. ADDRESS VA Medical Center, Perry Point, MD 21902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/8/86		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Maryland		
24. FUNERAL DIRECTOR NAME Ralph E. Hicks					25a. DATE REC'D. BY REGISTRAR MAY 9 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2032 COTTON FIBER

DAVID WINSTON



00-07500

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 4 1

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
MALETA M JOHNSON		5 16 86		17:25 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	76 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Wilm. De.	U.S.A.		Cecil Co MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
ELKTON	UNION HOSPITAL OF CECIL COUNTY		Nurse		Health Care
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland		Cecil	North East	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	33 Drive, Carr Road 21901
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		
ROY	BLANCHE		221 07 7868		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		221 07 7868		Mrs. Madaline R. Tatman 21921	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro Vascular Accident					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR P.M.	19			
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 85 to 5-16 19 86, that (I) (we) lost saw the deceased alive on 5-16 19 86, and that in (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE		22c. DATE SIGNED		
Sheelmoham S. Saehdel M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5-19-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
Sheelmoham S. Saehdel M.D.	ELKTON MD 21921				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	5/19/86	Bethel Cemetery	Ches. City, Cecil Md.		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hicks Home for Funerals	Elkton, Md. MAY 23 1986		Julia Davidson-Randall		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please attach carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Item 23b, FilmG620 10/8/86jab

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 4 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ronie - Joyner			2a. DATE OF DEATH MONTH 5 DAY 14 YEAR 86			2b. HOUR 555 A					
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH 12 DAY 1 YEAR 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.					
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Custodian			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Cecil Co.		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 314 Friendship Rd 21921		
14. FATHER'S NAME FIRST Ross MIDDLE Joyner LAST Joyner				15. MOTHER'S MAIDEN NAME FIRST Alma MIDDLE Stephenson LAST Stephenson (D)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 238-38-8657		17. INFORMANT Jeanette Joyner				ADDRESS 314 Friendship Rd			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 3/12 , 19 86 , to 5/14 , 19 86 , that (1) (we) last saw the deceased alive on 3/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ehsanur Rahman MD				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ehsanur Rahman MD				22e. ADDRESS Newark Del			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/17/87		23c. NAME OF CEMETERY OR CREMATORY Bohemia Manor		23d. LOCATION CITY OR TOWN Chesapeake COUNTY Maryland STATE	
24. FUNERAL DIRECTOR NAME Stewart				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 16 1986 Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12380-00

GEN

COLON



WATER

MAY 2 1960

00-08478

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Albert F. Kennedy			2a. DATE OF DEATH MONTH DAY YEAR 5/19/86			2b. HOUR 0850 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 20 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 00 00		8. IF UNDER 24 HRS HOURS MIN. 00 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.		
10. CITY OR TOWN OF DEATH ELKTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL OF CECIL COUNTY			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter			12b. KIND OF BUSINESS OR INDUSTRY Education		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Cecil		13c. CITY OR TOWN Earlville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK KENNEDY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ENGLAND					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 218 10 0343			17. INFORMANT ADDRESS 5 Old Farm Rd., Earlville, Md. Mrs. Carmen C. Kennedy					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease Over 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c) 10 min.? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 8-3-62 19 62 to 5-19 19 86 , that (I) (we) lost saw the deceased alive on 5-21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. Ralph Brown						DEGREE MO			22c. DATE SIGNED 5/19/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Ralph Brown						22e. ADDRESS 237 E. Main St., Elkton, Md 21921					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/22/86			23c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cecil Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Hicks Home for Funerals, Elkton, Md. Ralph E. Hicks						25a. DATE REC'D. BY REGISTRAR JUN 4 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Henderson		

20% COTTON FIBER

MADE IN U.S.A.



00-00113

MADE IN U.S.A.

00-07428

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 4 4 4

REG. NO.

1- FOR
STATE
REGISTRAR

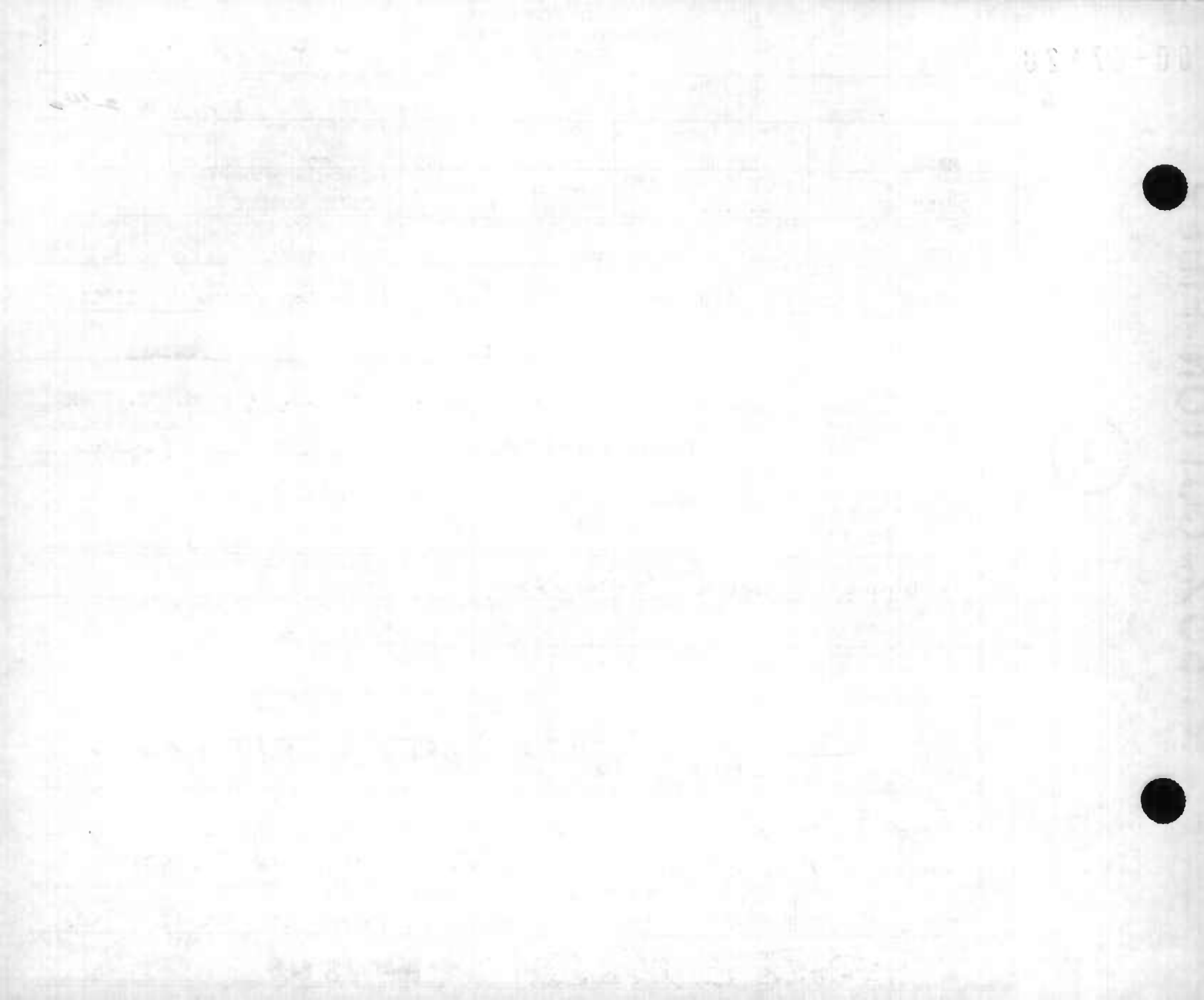
1. DECEASED NAME (TYPE OR PRINT) HERMAN			2a. DATE OF DEATH MONTH DAY YEAR MAY 18, 1986			2b. HOUR 2:10 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 4, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 136 Avalon Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Baltimore City Government	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 136 Avalon Avenue 21921	
14. FATHER'S NAME FIRST MIDDLE LAST CONSTANTINO LANZI			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZIACA FONTANA						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 07 8886		17. INFORMANT ADDRESS Dr. Joseph D. Lanzi, M.D. Elkton, Md. 21921					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mesothelioma DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Background exposure to asbestos									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 7/18 19 85 to 5/18 19 86 , that (we) last saw the deceased alive on 5/18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edgar E. Folk				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk 3rd, MD.				22e. ADDRESS 304 N. Main St., Elkton, MD 21921					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/20/86		23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill Cecil Md.			
24. FUNERAL DIRECTOR Hicks Home for Funerals, Ralph C. Hicks				25a. DATE REC'D. BY REGISTRAR MAY 23 1986		25b. REGISTRAR'S SIGNATURE Ralph C. Hicks			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.



00-05851

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 4 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA C LITTLE			2a. DATE OF DEATH MONTH DAY YEAR 5 1 86			2b. HOUR 20.47P ^M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 8, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carl J. Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Alexander			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-16-0875		17. INFORMANT ADDRESS 1448 Old E. Phila. Rd. Chester A. Little Elkton, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma Ovary with Metastasis

DUE TO OR AS A CONSEQUENCE OF

(b) Pancytopenia 2° to chemotherapy

DUE TO OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan</u> , 19 <u>86</u> , to <u>MAY 1</u> , 19 <u>86</u> , that (I) was last saw the deceased alive on <u>may 1</u> , 19 <u>86</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) we (did) (do not) view the body after death.							
22b. SIGNATURE JAYANTILAL K. PATEL MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTILAL K. PATEL MD				22e. ADDRESS 123 Singorly Ave Elkton MD 21921			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 5 1986		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE ELKTON CEIL MD	
24. FUNERAL DIRECTOR NAME See Funeral Home 259 E Main St Elkton				25a. DATE REC'D. BY REGISTRAR MAY 06 1986			
25b. REGISTRAR'S SIGNATURE John Anderson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued, attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. This permit must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

13322-00



NO. 11111111
COTTON MOTION

MAY 19 1960
MAY 19 1960

00-08646

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 4 4 4 6

1. DECEASED NAME (TYPE OR PRINT) CHARLES ELLSWORTH LONG			2a. DATE OF DEATH MONTH DAY YEAR MAY 23, 1986			2b. HOUR 2:30 a				
3. SEX MALE		4. RACE CA UC.		5. DATE OF BIRTH MAR. 22, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CECIL CO. MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD				
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSP. OF CECIL CO.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARMING		
13a. STATE MARYLAND			13b. COUNTY CECIL		13c. CITY OR TOWN CECILTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES LONG			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 215-36-8194			17. INFORMANT ADDRESS HELEN LONG wife same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R Hall MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-23-86 MD 21913		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY E. HALL			22e. ADDRESS CECIL-KENT HEALTH SERVICES, CECILTON							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAY 25/86		23c. NAME OF CEMETERY OR CREMATORY JOHNTOWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE EARLEVILLE, CECIL, MD			
24. FUNERAL DIRECTOR NAME FELLOWS F.H. 226 E. MAIN ST. CECILTON,						25a. DATE REC'D. BY REGISTRAR MAY 23 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove correct pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The placard removed from the carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the removal or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the

MEDICAL CERTIFICATION

#1, per F.H. 5/29/86 kam		STATE OF MARYLAND		8614447	
FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8614447	
CERTIFICATE OF DEATH		REG. NO.		8614447	
1 DECEASED NAME (TYPE OR PRINT)		FIRST Agnes MIDDLE V. LAST Lee		2a DATE OF DEATH MONTH DAY YEAR 5-24-86 8:55 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 7 7 1890	
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b CITIZEN OF WHAT COUNTRY? USA		8 AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
10 CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurilwood Nursing Home		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Md. Cecil Rising Sun		13d INSIDE CITY LIMITS? YES [X] NO []		13e STREET ADDRESS / ZIP CODE 110 Reynolds Ave. 21911	
14 FATHER'S NAME FIRST MIDDLE LAST William H. Rowley		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McDermott		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b SOCIAL SECURITY NO. 049-16-5958		17 INFORMANT ADDRESS Joan Jugler Rising Sun, Md. 21911		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE heart failure. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES [] NO []	
21a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK []		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 11 APRIL 1986 to Present 1986, that (I) (we) lost saw the deceased alive on 5/22/86 1986, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (not) sign the body after death.		22b. SIGNATURE (Type or Print) M.D. 22c. DATE SIGNED 5/26/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5-28-86		23c NAME OF CEMETERY OR CREMATORY St. Peters Cemetery Danbury Fairfield Conn.	
24 FUNERAL DIRECTOR NAME R.T. Foard		ADDRESS Rising Sun Md. 21911		25. DATE RECEIVED BY REGISTRAR MAY 28 1986 26. REGISTRAR'S SIGNATURE	

0-07028

SECRET

SECRET



00-08317

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF THE WORD "DECEASED". IN CASE OF A BURIAL, THE MEDICAL EXAMINER'S PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, ALONG WITH FORM #W-3, REMAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14448

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ellis Kennedy Manly		2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 5 29 86		2b. HOUR 11:50A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 20 1932	6. AGE (IN YEARS) (LAST BIRTHDAY) 54 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 30 86
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County		10. CITY OR TOWN OF DEATH North East		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 South Main Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Antique Dealer		12b. KIND OF BUSINESS OR INDUSTRY Sales
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN North East	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH STUART MANLEY, SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE PEARL RIALE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 171-26-4279		17. INFORMANT Betty Weaver Manley, 32 North East, MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Chronic alcoholism, Severe malnutrition				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE J. C. Gonzalez-Vitale		TITLE (SPECIFY) Deputy		DATE SIGNED 5-30-86
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vitale MD		ADDRESS Union Hospital, Elkton MD 21901		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6-2-86	23c. NAME OF CEMETERY OR CREMATORY Birmingham-Lafayette	23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester PA	
24. FUNERAL DIRECTOR Robert J. [Signature]		25a. DATE REC'D. BY REGISTRAR JUN 3 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

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00-07049

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14449
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Ray B. Mayopoulos		2a. DATE OF DEATH MONTH DAY YEAR May 13, 1986		2b. HOUR 6:05A M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Mayopoulos		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Retta Beach		16. SOCIAL SECURITY NO. 180 20 5301			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 2/28/46-5/25/46		17. INFORMANT John Mayopoulos		ADDRESS 8403 Kavenaugh Rd. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>May 17</u> , 19 <u>83</u> , to <u>May 13</u> , 19 <u>86</u> , that <u>XX</u> (we) last saw the deceased alive on <u>May 13</u> , 19 <u>86</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (we) (did) <u>XX</u> view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Chris Berchelmann, M.D.				22c. DATE SIGNED 5-13-86			
22d. ADDRESS VA Medical Center, Perry Point, MD 21902				22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 16, 1986		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris & Co.		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Pa.	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u> Lee A. Patterson & Son Perryville, Maryland				25a. DATE REC'D BY REGISTRAR MAY 20 1986			
25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>				25c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified at once.

BP

2025 EDITION 11/82

DO NOT WRITE IN THESE SPACES

DO NOT WRITE IN THESE SPACES



0-05757

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14450
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) IRVING PHILIP MENDELSON			2a. DATE OF DEATH MONTH DAY YEAR MAY 1 1986			2b. HOUR 4:55AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 24 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD				
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ANALYST (RET)		12b. KIND OF BUSINESS OR INDUSTRY N.S.A.		
13a. STATE MARYLAND		13b. COUNTY A A CO.		13c. CITY OR TOWN MILLERSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 493 OLD ORCHARD CIRCLE 21108		
14. FATHER'S NAME FIRST MIDDLE LAST LEWIS MENDELSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE BISHOP							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 215 18 0187		17. INFORMANT (Wife) ADDRESS Mrs. Jean D. Mendelsohn Same as 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE CVA'S			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 9 , 19 85 , to MAY 1 , 19 86 , that (I) (we) lost saw the deceased alive on MAY 1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE <i>Glendon Rayson</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-1-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON				22e. ADDRESS VAMC, PERRY POINT, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 6, 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer Va.	
24. FUNERAL DIRECTOR NAME ADDRESS SINGLETON FUNERAL HOME GLENBURNIE MD				25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE <i>Glendon Rayson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON LIME

WIND

WIND



00-06373

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

14451

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (Type Print) (Wilhelm) William A. Mielke		2a. DATE OF DEATH MONTH DAY YEAR May 11, 1986		2b. HOUR 5:40PM	
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 8-7-1899 YEAR		6 AGE (IN YEARS (LAST BIRTHDAY)) 86 YRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN) ILLINOIS	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH PERRY POINT	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VAMC, PERRY POINT		12a. USUAL OCCUPATION YD. FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY B&O RR
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND 13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS (ZIP CODE) 4205 WOODLEE AVENUE	
14. FATHER'S NAME UNKNOWN MIDDLE LAST		15. MOTHER'S MAIDEN NAME UNKNOWN MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (OR UNKNOWN)		16b. SOCIAL SECURITY NO. 705 09 4992		17. INFORMANT ADDRESS VAMC, Perry Point, Maryland	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardio pulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that ~~xxx~~ (this hospital) attended the deceased from **11-27-** 19 **85** to **5-11-1986** that ~~xxx~~ (we) last saw the deceased alive on **5-11-1986**, and that in ~~xxx~~ (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.

21b. SIGNATURE <i>Christopher M. Berchermann</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 5-11-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER M. BERCHELMANN, M.D.		22e. ADDRESS VAMC, Perry Point, Maryland	

23a. BURIAL, CREMATION, REMOVAL (Type Print) BURIAL	23b. DATE 5-15-86	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS Cvach Funeral Home 1211 Chesaco Ave., Balt., Md.		25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 13 1986 <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department.

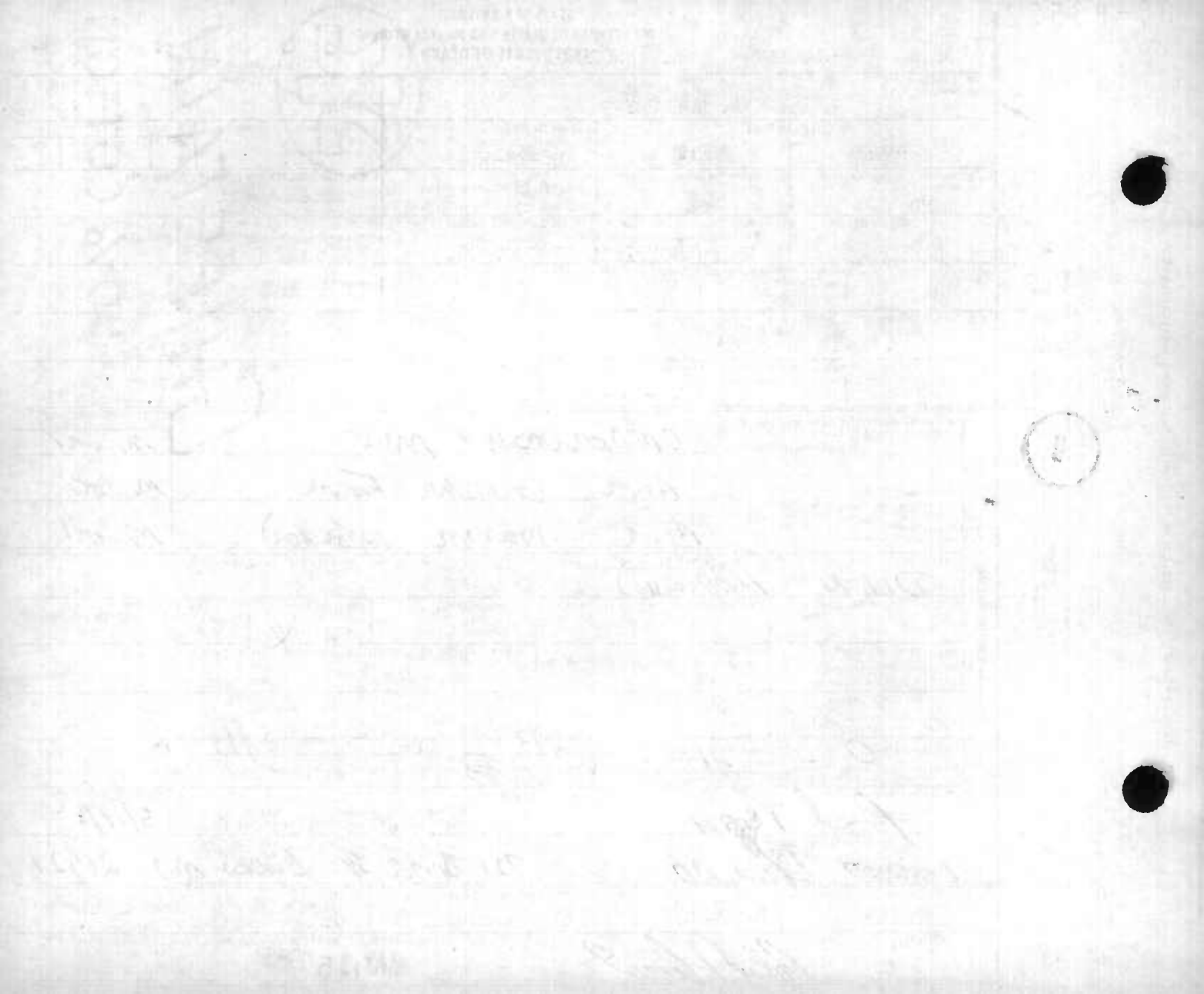
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 3 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		LILLIAN A. NORBURY		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 6 1 4 4 5 2		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				LILLIAN A. NORBURY				2a. DATE OF DEATH MONTH DAY YEAR	
								05-14-86	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
FEMALE		WHITE		06-23-13		72 YRS.		1:00 A.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
MD		USA				CECIL COUNTY		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ELKTON		UNION HOSPITAL OF CEC. CO.				Homemaker		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
MD		CE		ELKTON				77 Arbutus St. 21921	
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Benjamin Racine				Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
No				216-20-0062		Beverly Calvert Elkton, Md. 21921			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY DISTRESS</u>								<u>MINUTES</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE CONGESTIVE FAILURE</u>								<u>MINUTES</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE MYOCARDIAL INFARCTION</u>								<u>MINUTES</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETES HYPERTENSION</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
								20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> , 19 <u>86</u> , to <u>5/18</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>Samuel J. [Signature]</u>								<u>5/14/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
<u>Samuel J. [Signature]</u>				<u>721 BRIDGE ST ELKTON, MD 21921</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5-17-86		North East Meth		North East Cecil Md.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Brough Funeral Home North East, Md.</u>						<u>MAY 15 1986</u>			



00-07314

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 4 5 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RAY		CHAPMAN		NORMAN		MAY 20 1986	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		White		May 17, 1896		90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Galax Virginia		U.S.A.				Cecil County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point (21902)		VA MEDICAL CENTER PERRY POINT MD		Former		Agriculture	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Harford Co		Street (21154)		3213 COPENHAVEN ROAD 21154	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Matthew W. Norman		Margie T. Hampton		YES-Army W.W.1		219-36-0088	
17. INFORMANT (Son) 836-1460 ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST		17. INFORMANT (Son) 836-1460 ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mr. John H. Norman 3241 Ady Road Street, Maryland 21154		DUE TO, OR AS A CONSEQUENCE OF (b) C O P D					
		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 22, 1986, to MAY 20, 1986, that (I) (we) last saw the deceased alive on MAY 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
PREM LAL				MAY 20, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS	
PREM LAL		VA MEDICAL CENTER PERRY POINT MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		May 22, 1986		Bel Air Memorial Gardens		Bel Air, Harford Co., Maryland 21014	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FOSTER FUNERAL HOME		50 W. Broadway & Williams St 21014		MAY 23 1986		Jana Davidson-Randall	

2014-2015 2015-2016 2016-2017 2017-2018 2018-2019 2019-2020 2020-2021 2021-2022 2022-2023 2023-2024 2024-2025 2025-2026 2026-2027 2027-2028 2028-2029 2029-2030 2030-2031 2031-2032 2032-2033 2033-2034 2034-2035 2035-2036 2036-2037 2037-2038 2038-2039 2039-2040 2040-2041 2041-2042 2042-2043 2043-2044 2044-2045 2045-2046 2046-2047 2047-2048 2048-2049 2049-2050 2050-2051 2051-2052 2052-2053 2053-2054 2054-2055 2055-2056 2056-2057 2057-2058 2058-2059 2059-2060 2060-2061 2061-2062 2062-2063 2063-2064 2064-2065 2065-2066 2066-2067 2067-2068 2068-2069 2069-2070 2070-2071 2071-2072 2072-2073 2073-2074 2074-2075 2075-2076 2076-2077 2077-2078 2078-2079 2079-2080 2080-2081 2081-2082 2082-2083 2083-2084 2084-2085 2085-2086 2086-2087 2087-2088 2088-2089 2089-2090 2090-2091 2091-2092 2092-2093 2093-2094 2094-2095 2095-2096 2096-2097 2097-2098 2098-2099 2099-2100 2100-2101 2101-2102 2102-2103 2103-2104 2104-2105 2105-2106 2106-2107 2107-2108 2108-2109 2109-2110 2110-2111 2111-2112 2112-2113 2113-2114 2114-2115 2115-2116 2116-2117 2117-2118 2118-2119 2119-2120 2120-2121 2121-2122 2122-2123 2123-2124 2124-2125 2125-2126 2126-2127 2127-2128 2128-2129 2129-2130 2130-2131 2131-2132 2132-2133 2133-2134 2134-2135 2135-2136 2136-2137 2137-2138 2138-2139 2139-2140 2140-2141 2141-2142 2142-2143 2143-2144 2144-2145 2145-2146 2146-2147 2147-2148 2148-2149 2149-2150 2150-2151 2151-2152 2152-2153 2153-2154 2154-2155 2155-2156 2156-2157 2157-2158 2158-2159 2159-2160 2160-2161 2161-2162 2162-2163 2163-2164 2164-2165 2165-2166 2166-2167 2167-2168 2168-2169 2169-2170 2170-2171 2171-2172 2172-2173 2173-2174 2174-2175 2175-2176 2176-2177 2177-2178 2178-2179 2179-2180 2180-2181 2181-2182 2182-2183 2183-2184 2184-2185 2185-2186 2186-2187 2187-2188 2188-2189 2189-2190 2190-2191 2191-2192 2192-2193 2193-2194 2194-2195 2195-2196 2196-2197 2197-2198 2198-2199 2199-2200 2200-2201 2201-2202 2202-2203 2203-2204 2204-2205 2205-2206 2206-2207 2207-2208 2208-2209 2209-2210 2210-2211 2211-2212 2212-2213 2213-2214 2214-2215 2215-2216 2216-2217 2217-2218 2218-2219 2219-2220 2220-2221 2221-2222 2222-2223 2223-2224 2224-2225 2225-2226 2226-2227 2227-2228 2228-2229 2229-2230 2230-2231 2231-2232 2232-2233 2233-2234 2234-2235 2235-2236 2236-2237 2237-2238 2238-2239 2239-2240 2240-2241 2241-2242 2242-2243 2243-2244 2244-2245 2245-2246 2246-2247 2247-2248 2248-2249 2249-2250 2250-2251 2251-2252 2252-2253 2253-2254 2254-2255 2255-2256 2256-2257 2257-2258 2258-2259 2259-2260 2260-2261 2261-2262 2262-2263 2263-2264 2264-2265 2265-2266 2266-2267 2267-2268 2268-2269 2269-2270 2270-2271 2271-2272 2272-2273 2273-2274 2274-2275 2275-2276 2276-2277 2277-2278 2278-2279 2279-2280 2280-2281 2281-2282 2282-2283 2283-2284 2284-2285 2285-2286 2286-2287 2287-2288 2288-2289 2289-2290 2290-2291 2291-2292 2292-2293 2293-2294 2294-2295 2295-2296 2296-2297 2297-2298 2298-2299 2299-2300 2300-2301 2301-2302 2302-2303 2303-2304 2304-2305 2305-2306 2306-2307 2307-2308 2308-2309 2309-2310 2310-2311 2311-2312 2312-2313 2313-2314 2314-2315 2315-2316 2316-2317 2317-2318 2318-2319 2319-2320 2320-2321 2321-2322 2322-2323 2323-2324 2324-2325 2325-2326 2326-2327 2327-2328 2328-2329 2329-2330 2330-2331 2331-2332 2332-2333 2333-2334 2334-2335 2335-2336 2336-2337 2337-2338 2338-2339 2339-2340 2340-2341 2341-2342 2342-2343 2343-2344 2344-2345 2345-2346 2346-2347 2347-2348 2348-2349 2349-2350 2350-2351 2351-2352 2352-2353 2353-2354 2354-2355 2355-2356 2356-2357 2357-2358 2358-2359 2359-2360 2360-2361 2361-2362 2362-2363 2363-2364 2364-2365 2365-2366 2366-2367 2367-2368 2368-2369 2369-2370 2370-2371 2371-2372 2372-2373 2373-2374 2374-2375 2375-2376 2376-2377 2377-2378 2378-2379 2379-2380 2380-2381 2381-2382 2382-2383 2383-2384 2384-2385 2385-2386 2386-2387 2387-2388 2388-2389 2389-2390 2390-2391 2391-2392 2392-2393 2393-2394 2394-2395 2395-2396 2396-2397 2397-2398 2398-2399 2399-2400 2400-2401 2401-2402 2402-2403 2403-2404 2404-2405 2405-2406 2406-2407 2407-2408 2408-2409 2409-2410 2410-2411 2411-2412 2412-2413 2413-2414 2414-2415 2415-2416 2416-2417 2417-2418 2418-2419 2419-2420 2420-2421 2421-2422 2422-2423 2423

00-05868

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

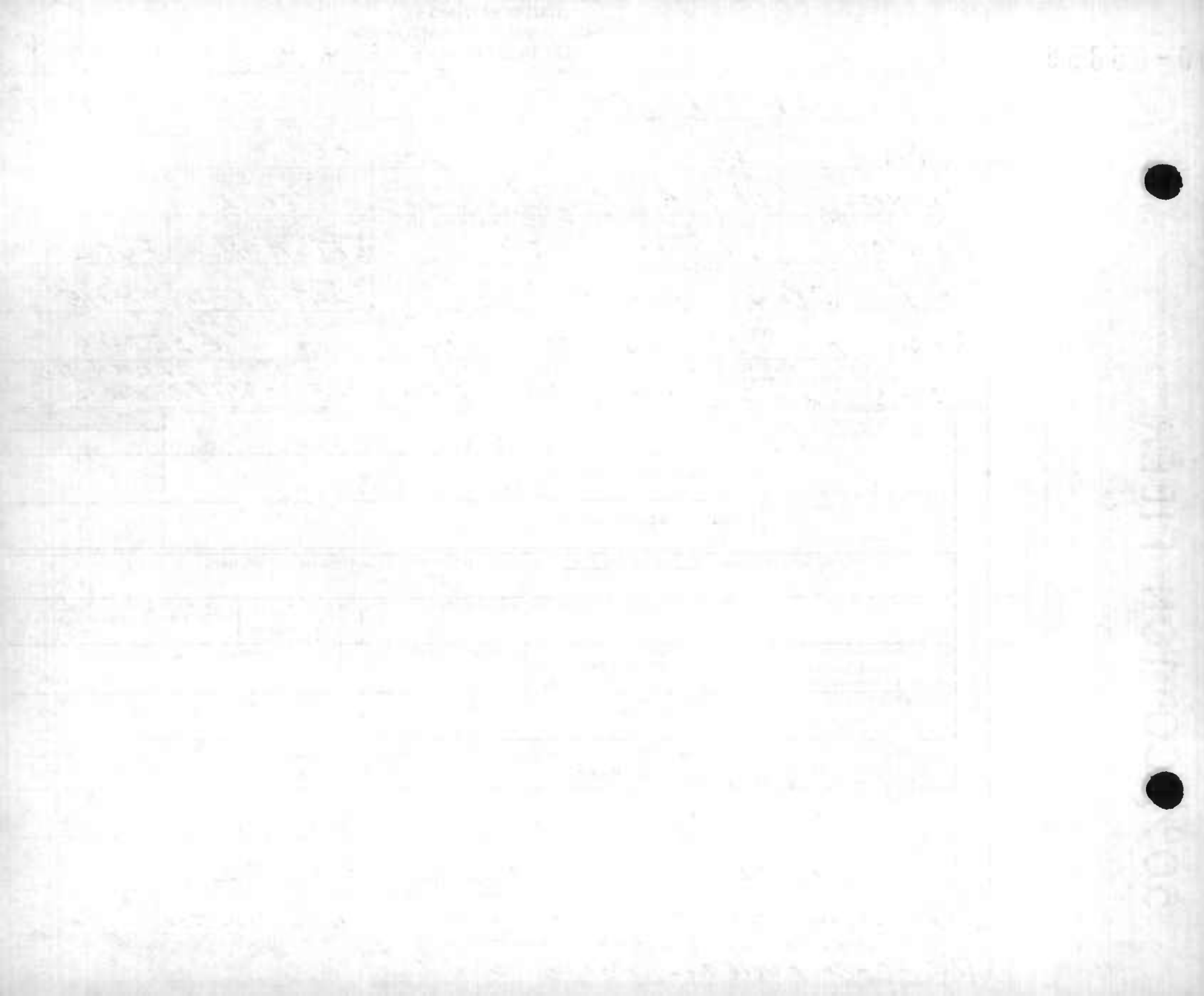
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8614454

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) G'ERALD T. OESTERRICH		2a. DATE OF DEATH MONTH 5 DAY 4 YEAR 86		2b. HOUR 10.47 ^A _M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 1 DAY 7 YEAR 26		6. AGE (IN YEARS LAST BIRTHDAY) 60
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINN.	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILMINGTON HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. ADM.	12b. KIND OF BUSINESS OR INDUSTRY RETIRED
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY CECIL 13c. CITY OR TOWN ELKTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 258 WEED LANE	
14. FATHER'S NAME FIRST ROD MIDDLE E. LAST OESTERREICH		15. MOTHER'S MAIDEN NAME FIRST EDNA MIDDLE GERTHS LAST GERTHS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 474-12-3521		17. INFORMANT ADDRESS ELKTON MD JEANNINE OESTERREICH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 86		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 5-3-86 , to 5-5-86 , that (I) (we) lost saw the deceased alive on 5-4-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Yogesh Patel		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/5/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. PATEL		22e. ADDRESS WILMINGTON DE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 5-6-86	23c. NAME OF CEMETERY OR CREMATORY SILVERBROOK	23d. LOCATION CITY OR TOWN WILMINGTON COUNTY D.E. STATE DE	
24. FUNERAL DIRECTOR NAME R.T. FOARD ADDRESS FUNERAL HOME MD		25a. DEATH CERTIFICATE REG. NO. 8614454 25b. REGISTRAR'S SIGNATURE [Signature]		



75
00-08979

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RICHARD ANDREW PAINTER				May 28, 1986		1:05pm	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male	White	4 25 26		60 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.			Cecil County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Perry Point, Md.	VA Medical Center		Cable		Phone		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE		
Md.		Cecil	Perryville		542 Richmond St. 21093		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Samuel Painter		Thelma Campbell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		WWII 220-18-7447		Mrs. Olive Painter - Same as #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest			
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of stomach & esophagus			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) this hospital attended the deceased from May 26, 19 86, to May 28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE J. R. GARCIA, M.D.				22c. DATE SIGNED 5-28-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
J. R. GARCIA, M.D.				VA Medical Center, Perry Point, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		5-28-86					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Anatomy Board of Maryland, Baltimore, Md.				JUN 04 1986		John Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-00000



Handwritten signature or text, possibly "M. J. ..."

00-08230

DIVISION OF VITAL RECORDS, 202 W. PASTOR ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 202 W. PASTOR STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

J 4450

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Jacob		MIDDLE Willard		LAST Pyle		2a. DATE KNOWN OF DEATH		X MONTH 5		DAY 27		YEAR 1986		2b. HOUR 900P	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 29 26		59 YRS.		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		5 27 1986		2d. HOUR 900P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		Cecil County		MD.					
10. CITY OR TOWN OF DEATH CONOWINGO		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		620 Mt Zoar Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY		SELFEMP.					
13a. STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN CONOWINGO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS MT ZOAR RD.		21918							
14. FATHER'S NAME FIRST MIDDLE LAST CLYDE GEORGE PYLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANCY STYER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT DAVID W. PYLE		ADDRESS 735 FIRST RD.		PORT DEPOSIT MD.		21918			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED		5-27-86									
EXAMINER'S NAME (TYPE OR PRINT)		Juan C. Gonzalez-Vital		ADDRESS		Union Hospital Elkton MD 21921											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		5-30-86		Brookview Cemetery		Rising Sun		Cecil		MD							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
RT FORD FUNERAL		HOME		21911		JUN 2 1986											



00-06078

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMM-16 50M7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614451

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH	
LOUIS E RAINE		Male		White		Nov. 17, 1918	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Phila. Pa.		U.S.A.				Cecil Co. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
EIKTON		Union Hospital		Shipfitter		Ind.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Cecil		North East		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
John Raine		Effie Singleton		No		217-09-4349	
17. INFORMANT		18. ADDRESS		19. DATE OF OPERATION		20a. AUTOPSY?	
106 Wallace Ave.		Edith Raine North East, Md. 21901				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsisemia, Dehydration, pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke after removal of tumor.</u>		22. SIGNATURE		22c. DATE SIGNED	
YES <input type="checkbox"/> NO <input type="checkbox"/>				M. Sachdev MD			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
M. Sachdev		North East Md		Burial		5-10-86	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN	
Imm. Conception		Cherry Hill Cecil Md.					
24. FUNERAL HOME		25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE	
Cherry Hill Funeral Home North East, Md.		MAY 9 1986		John Raine			

MEDICAL CERTIFICATION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 10, 1900

ALBANY: J.B. LEECH, STATE PRINTER, 1900.

00-08593

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate is carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or if a traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

14458

REG. NO.

1- FOR
STATE
REGISTRAR

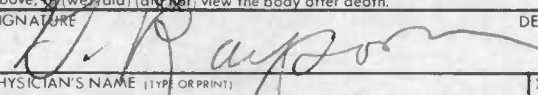

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Violet M. Raisin			2a. DATE OF DEATH MONTH DAY YEAR May 19 86		2b. HOUR 1020 AM
3. SEX female	4. RACE Colored	5. DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Middle Neck Md.	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General		12b. KIND OF BUSINESS OR INDUSTRY Domestic
13a. STATE Md.			13b. COUNTY Cecil	13c. CITY OR TOWN Warwick	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Henson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-03-4461		17. INFORMANT MARGARET BRADSHAW grand daughter 133 Money Rd. Townsend, De.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dilative Cardiac myopathy DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. age.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from May 19 85 to 19 May 19 86, that (I) (we) last saw the deceased alive on 19 May 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Wallace Openshain		DEGREE MD.		22c. DATE SIGNED 20 May 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Openshain MD.		22e. ADDRESS Cecilton Md.			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/25/86		23c. NAME OF CEMETERY OR CREMATORIUM Bohemia Manor	
24. FUNERAL DIRECTOR NAME GEE FUNERAL Home		24b. ADDRESS 2596 MAIN ST ELKTON		25a. DATE REC'D. BY REGISTRAR JUL 1 1986	
25b. REGISTRAR'S SIGNATURE John Anderson		25c. REGISTRAR'S NAME John Anderson			

00-07115

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 5 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT G REYNOLDS			2a. DATE OF DEATH MONTH DAY YEAR MAY 14, 1986			2b. HOUR 11:12P			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 10 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.			
10. CITY OR TOWN OF DEATH PERRY POINT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. ARMY		12b. KIND OF BUSINESS OR INDUSTRY GOV'T	
13a. STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN COLORA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 435 COLORA RD. 21917	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT G. REYNOLDS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE SCHONEFEIDER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS SHIRLEY P. REYNOLDS (SAME AS 13 ABOVE)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC DISEASE (WIDESPREAD) DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 21 , 19 86 , to MAY 14 , 19 86 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MAY 14 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we did) (did not) view the body after death.									
22b. SIGNATURE  DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							22c. DATE SIGNED 5-14-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON, M.D.				22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-18-86		23c. NAME OF CEMETERY OR CREMATORY WEST NOTTINGHAM		23d. LOCATION CITY OR TOWN COUNTY STATE COLORA CECIL MD			
24. FUNERAL DIRECTOR NAME ADDRESS Foard Funeral Home, Rising Sun, Md.				25a. DATE RECD. BY REGISTRAR MAY 20 1986		25b. REGISTRAR'S SIGNATURE 			

completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP _____

DHMH - 16 60M 7/B4
(VRA 15, 4)

00-07112

NOTICE NO. 2

8

MAILED

MAY 20 1961

00-06590

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 6 0

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Stella O. Rominger			2a. DATE OF DEATH MONTH DAY YEAR 5/12/86			2b. HOUR 11 40 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 4 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ash Cty. N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood Nursing Cent.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home.			
13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN Charlestown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 342 Cather St. 21914		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Osborne				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Lewis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 237-56-7093		17. INFORMANT P.O. Box 83 Ruth E. Lewis Charlestown, Md. 21914						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anterior subarachnoid hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Goiter on Thyroid; Renal Failure; Dementia, chronic HTI</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <i>May 12</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>May 3</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles M. Hensley</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>12 May 86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-17-86		23c. NAME OF CEMETERY OR CREMATORY Sutherland Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sutherland Ash N.C.				
24. FUNERAL DIRECTOR NAME Sutherland Funeral Home North East, Md.					25a. DATE REC'D. BY REGISTRAR MAY 15 1986					25b. REGISTRAR'S SIGNATURE <i>James J. Fendell</i>	

BP



BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

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Film G616 item 22a

1- FOR 6/16/86 rja
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 6 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charlotte Velma Ryon			2a. DATE OF DEATH MONTH DAY YEAR May 8, 1986		2b. HOUR P. 10:15				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own home		
13a. STATE MD		13b. COUNTY CHARLES		13c. CITY OR TOWN INDIAN HEAD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #3 Green Meadows Drive 20640	
14. FATHER'S NAME FIRST MIDDLE LAST Evan Ward Hartman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Viola Arthur			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 223-16-8893	
17. INFORMANT Spouse			17. INFORMANT John C. Ryon			17. INFORMANT same as 13			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-9-86 , 19____, to 5-8-86 , 19____, that (I) (we) lost saw the deceased alive on 5-8-86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Krishan M. Mathur			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-9-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Krishan Mathur, M.D.			22e. ADDRESS Waldorf, Md. 20601						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 12, '86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria VA		
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 12 1986			

MEDICAL CERTIFICATION

W. A.

Nov. 20 1912

Tealia

Hammerhead
2000
13 Green Mountain Drive

Corps

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Nov. 20 1912

123-1-100 Nov. 20 1912

name as is

20%
WILL
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0-07163

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows only injury, or other trauma, the medical examiner must be contacted once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 4 6 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
ELOISE C. SCHWATKA				May 15, 1986		10:45 PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS.	
Female	W	May 17, 1919		66		YES			
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia	U.S.A.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Cecil County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN HOSPITAL FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (ENTER WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Elkton	Union Hospital		Cashier		Drug Store				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Delaware		New Castle		Newark		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		350 Liberty Terrace	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Wilkie Earl Collision		Lillian Freshman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		236-16-3437		Carl W. Schwatka II - Newark, DE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>acute renal failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:									
(b) <u>_____</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>_____</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
<u>pneumococcal sepsis, acute pulmonary edema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-6-80</u> to <u>5-15</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5-15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Kenneth Lewis, MD						5/19/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
KENNETH LEWIS		12 Pennington St Middletown, DE 19705							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		May 19, 1986		Townsend Cm		Townsend		N.C. Del.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert C. Hutchinson		MAY 21 1986		John A. Borden					

ELIOT C. SCHWARTZ

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00-07471

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 4 4 6 3

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
DELORES TATE SEYMOUR						5-19-86			19			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
F		B		11 14 55		30 YRS.		MONTHS		DAYS		5-19-86		19 6:40A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.				U.S.A.								Cecil county MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
CECIL COUNTY				N/bd. I-95, 400 mile marker Cecil County								REALTORS			
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
N.C.				HIGH POINT				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				600 WOODROW AVENUE			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES?				17. INFORMANT			
UNKNOWN				RELEASE TATE REEDER				NO				N.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
PART 1 DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a) Multiple injuries and thermal burns								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
7 8/21				DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				5:30AM 5-19-86				driver of an auto which struck the rear of a disabled bus							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				N/bd. I-95, 400mi. marker Cecil Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:				Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				TITLE (SPECIFY)				DATE SIGNED			
ACTUAL SIGNATURE				M.D. Assistant				MEDICAL EXAMINER				5-19-86			
EXAMINER'S NAME (TYPE OR PRINT)				Margarita A. Korell, M.D.				ADDRESS				111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL				5-25-86				OAKWOOD CEMETERY				HIGHPOINT MARYLAND			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
WM.C.MARCH FUNERAL HOME INC. 1101 E.NORTH AVE.				MAY 23 1986											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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 (VR 415 ME (5))

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RECEIVED NOTICE

RECEIVED NOTICE



RECEIVED NOTICE

00-07473

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRINT IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14464	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH MATED	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DEMERTUIS RAYVON SEYMOUR										2b. HOUR	
3. SEX M 4. RACE B 5. DATE OF BIRTH MONTH DAY YEAR 3 18 73 6. AGE (IN YEARS) LAST BIRTHDAY 13 YRS. 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS.										2c. DATE PRONOUNCED DEAD 5-19-86 2d. HOUR 6:40A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CECIL COUNTY N/bd. I-95, 400 mile marker Cecil County										12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE N.C. 13b. COUNTY HIGH POINT 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 600 WOODROW AVE. 99999											
14. FATHER'S NAME FIRST MIDDLE LAST RAYFORD SEYMOUR 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELORES TATE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT ADDRESS LUCY SEYMOUR 1100 E. WASHINGTON											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8121 IMMEDIATE CAUSE (a) Head and neck injuries and thermal burns DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:30A 5-19-86 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in an auto which struck the rear of a disabled vehicle											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) N/bd. I-95, 400mi. marker Cecil Co., Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Margarita A. Korell, M.D. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5-19-86											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 5-25-86 23c. NAME OF CEMETERY OR CREMATORY OAKFORD MEMORIAL 23d. LOCATION (CITY OR TOWN COUNTY STATE) HIGH POINT N.C.											
24. FUNERAL DIRECTOR NAME WM.C.MARCH FUNERAL HOME INC. ADDRESS 1101 E. NORTH AVE. 25a. DATE REC'D. BY REGISTRAR MAY 23 1986 25b. REGISTRAR'S SIGNATURE											

10-17-13

Handwritten text on the left margin, possibly a date or page number, including "10-17-13" and "10-17-13".



10-17-13

00-07472

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14465

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
RAYFORD			M.			SEYMOUR			5-19-86			19					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR					
M	B	8 14 52	33 YRS.			5-19-86			19			6:40A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
N.C.			U.S.A.						Cecil County MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
CECIL COUNTY			N/bd. I-95, 400 mi. marker Cecil County			LABORER											
13a. STATE												13b. CITY OR TOWN		13c. STREET ADDRESS		13d. INSIDE CITY LIMITS?	
N.C.												HIGH POINT		600 WOODROW AVENUE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
ANTHONY						SEYMOUR						LUCY GEORGE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
NO						244789518						LUCY SEYMOUR 1100 E. WASHINGTON DR.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a):																	
8121 Cranio-cerebral trauma																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																	
(b):																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c):																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				5:30AM 5-19-86				passenger of an auto which struck the rear of a disabled bus									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE)									
				hwy.				N/bd. I-95, 400mi. marker Cecil Co. Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED					
Margarita A. Korell				M.D. Assistant MEDICAL EXAMINER								5-19-86					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Margarita A. Korell, M.D.				111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (CITY OR TOWN, COUNTY, STATE)					
BURIAL				5-25-86				OAKWOOD MEMORIAL				HIGH POINT N.C.					
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
WM.C. MARCH FUNERAL HOME INC. 1101 E. NORTH AVE.								MAY 23 1986				Wm. March					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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00-07474

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN PART 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14466

1. DECEASED NAME (TYPE OR PRINT)		FIRST		LAST		7a. DATE KNOWN OF DEATH		7b. DATE OF DEATH		7c. DATE PRONOUNCED DEAD		7d. HOUR	
STERLING D. SEYMOUR						5-19-86		19		6:40A		M	
1. SEX	4. RACE	3. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.					
M	B	8 18 80		5 YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
N.C.		U.S.A.		WIDOWED		DIVORCED		Cecil County				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
CECIL COUNTY		N/bd. I-95, 400mi. marker Cecil County											
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
N.C.		HIGH POINT		YES		600 WOODROW AVE.						99999	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
RAYFORD		SEYMOUR		DELORES		TATE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		UNKNOWN		LUCY SEYMOUR		1100 E. WASHINGTON DR.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Craniocerebral trauma													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				5:30A 5-19-86				passenger in an auto which struck the rear of a disabled bus					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)				21f. CITY OR TOWN					
				hwy.				N/bd. I-95, 400mi. marker Cecil Co., Md.					
22a. I certify that I took charge of the remains described above, held on												Autopsy <input type="checkbox"/>	
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Margarita A. Korell, M.D.				M.D. Assistant MEDICAL EXAMINER				5-19-86					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
17a. BURIAL, CREMATION, REMOVAL				17b. DATE				17c. NAME OF CEMETERY OR CREMATORY					
BURIAL				5-25-86				OAKWOOD MEMORIAL					
17d. LOCATION				17e. CITY OR TOWN				17f. COUNTY					
				HIGH POINT				N.C.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR					
WM.C.MARCH FUNERAL HOME INC.				1101 E. NORTH AVE.				MAY 23 1986					
								25b. REGISTRAR'S SIGNATURE					
								Margarita A. Korell					

00-07476



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-05857

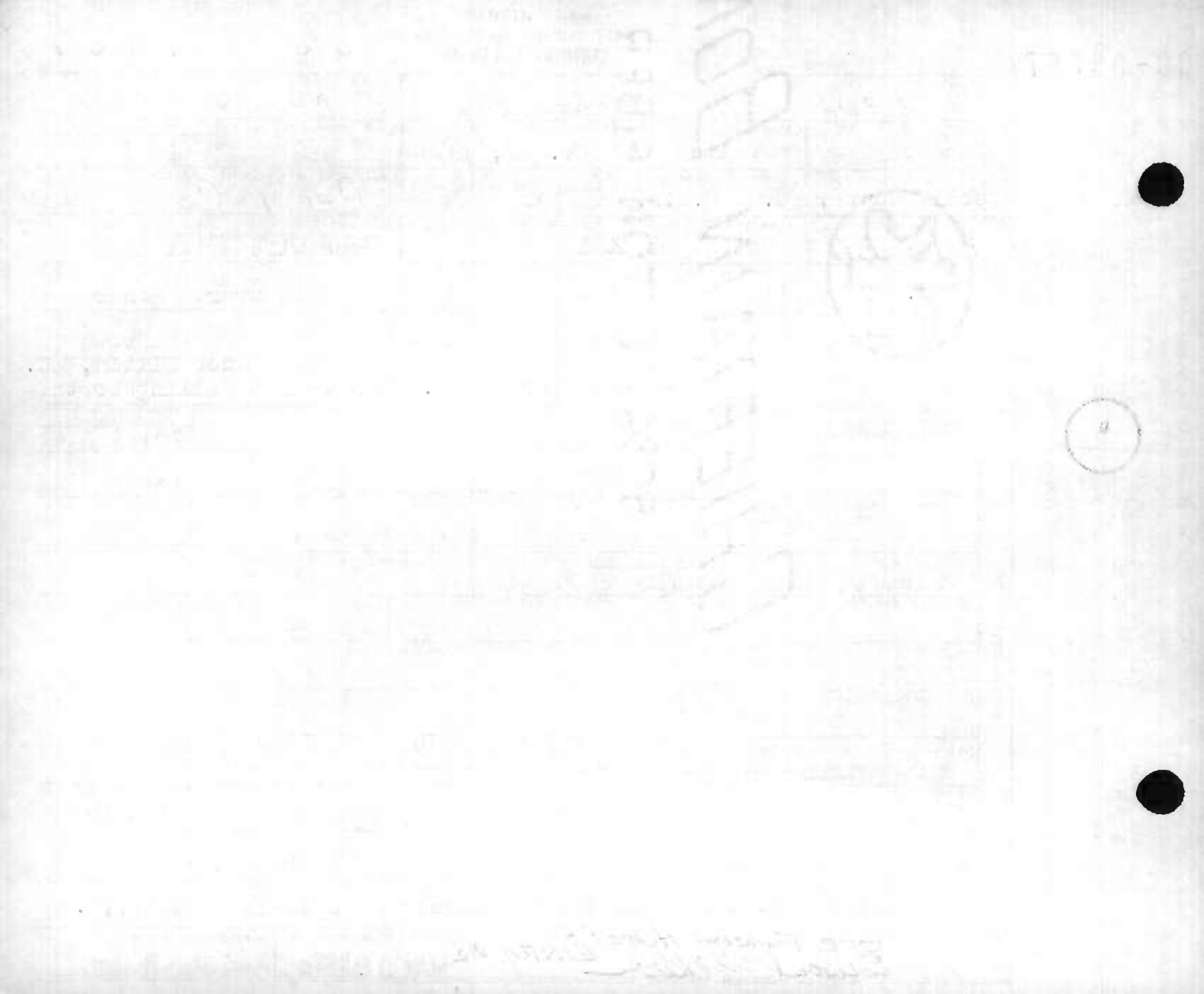
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14467
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LENA M. Stanley		2a. DATE OF DEATH MONTH DAY YEAR May 6 1986		2b. HOUR 5:07 P.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cecil County, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.	
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clifton Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Brown		13e. STREET ADDRESS / ZIP CODE 3 Hollingsworth Manor 21921			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-24-4481		17. INFORMANT ADDRESS Manor Elkton, Md. Forrest S. Stanley 323 Hollingsworth			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>5 days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Cerebral vascular disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> 19 <u>86</u> to <u>5/6</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edgar E. Folk, M.D.				DEGREE M.D.		22c. DATE SIGNED 5/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk, M.D.				22e. ADDRESS Union Hospital, Elkton, Md 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-9-86		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION Hopewell Cecil, Md.	
24. FUNERAL DIRECTOR NAME Gee Funeral Home, P.A. Edwoud Kish				25a. DATE REC'D. BY REGISTRAR MAY 08 1986			
				25b. REGISTRAR'S SIGNATURE Julia Swindon-Rodgers			



0-07911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 4 4 6 8			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha Stanton					2a. DATE OF DEATH MONTH DAY YEAR May 24, 1986			2b. HOUR 8:28 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wilm. Del.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.							
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 118 Huntsman Dr. 21921					
14. FATHER'S NAME FIRST MIDDLE LAST Harry Cross				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Barkley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-32-8357		17. INFORMANT ADDRESS 118 Huntsman Dr. Harriet Howland Elkton, Md. 21921									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus, Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old CVA, old MI</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (this hospital) attended the deceased from <u>4/3/73</u> , 19 <u>86</u> , to <u>5/25</u> , 19 <u>86</u> , that (I/we) lost saw the deceased alive on <u>2/19</u> , 19 <u>86</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Jui Chih Hsu</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5/27/86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu MD				22e. ADDRESS 223 West main st, Elkton, Md 21921									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-28-86		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill Cecil Md.						
24. FUNERAL DIRECTOR'S NAME <u>Crouch Funeral Home North East, Md.</u>						25a. DATE REC'D. BY REGISTRAR MAY 28 1986						25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

11250-0



00-06081

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 4 6 9

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CLARA			M	Stewart	5/3/86					M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		FEB. 4, 1906		80 YRS		MONTHS		DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Maryland		U.S.A.				Cecil Co					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ELKTON		UNION HOSPITAL OF CECIL COUNTY				HOMEMAKER					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		CECIL		ELK MILLS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21920			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
ARTHUR		BUTLER		MARY		A.		DILKS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		219 14 1898		Mrs. Alice V. Frazer		600 Jackson Hall Rd. Elkton, Md. 21921					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intraventricular Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~1/2 hour</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus - Adult onset</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>79</u> , to <u>May 3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>May 2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<u>Charles M. Hensgen</u>						5 May 86					
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS									
Charles M. Hensgen		North East Md 21901									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		May 6, 1986		North East Methodist		North East,		Cecil		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Hicks Home for Funerals,		MAY 9 1986		Julia Davidson-Randall							
Elkton, Md.											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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24 Oct 1942

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Class

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11 Nov

That was the end of the war

and the peace

James M. Smith

James M. Smith

James M. Smith



00-06356

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4470

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
FIRST MARY		MONTH DAY YEAR 5-6-86 19		M	
MIDDLE ANN		3. SEX		4. RACE	
LAST STICKLEY		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MONTH DAY YEAR May 23, 1958		LAST BIRTHDAY 32RS.		West Virginia	
8. MARried		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
XX NEVER MARRIED		Cecil County		Charlestown	
WIDOWED		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
DIVORCED		417 Bayview Avenue		Housewife	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
Maryland		Cecil		YES XX NO	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
FIRST MIDDLE LAST Robert Eugene Fox		FIRST MIDDLE LAST Betty Flesher		(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
229-80-5456		Beverly Lee Stickley, 417 Bayview Ave.		PART I DEATH WAS CAUSED BY:	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		IMMEDIATE CAUSE (a) Shotgun wound of head	
20. AUTOPSY?		21a. EXTERNAL CAUSE WAS		DUE TO, OR AS A CONSEQUENCE OF	
YES NO		UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		(b) DUE TO, OR AS A CONSEQUENCE OF	
NO		3:40 PM 5-6-86 19		(c) DUE TO, OR AS A CONSEQUENCE OF	
21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I	
HOUR A.M. MONTH DAY YEAR		self/innflicted		19a. DATE OF OPERATION	
3:40 PM 5-6-86 19		21d. INJURY OCCURRED		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		20. AUTOPSY?	
home		417 BAYVIEW AVE.		YES NO	
21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY	
417 BAYVIEW AVE.		CHARLESTOWN, MARYLAND		21i. STATE	
21j. I certify that I took charge of the remains described above, held on		21k. Autopsy		21l. Inspection	
death resulted from:		Natural causes		Accident	
Suicide		Homicide		Undetermined manner	
21m. ACTUAL SIGNATURE		21n. TITLE (SPECIFY)		21o. DATE SIGNED	
Dennis F. Smyth, M.D.		Assistant		5-7-86	
21p. EXAMINER'S NAME		21q. ADDRESS		21r. DATE REC'D. BY REGISTRAR	
(TYPE OR PRINT) Dennis F. Smyth, M.D.		111 Penn Street		21s. REGISTRAR'S SIGNATURE	
22a. BURIAL, CREMATION, REMOVAL		22b. NAME OF CEMETERY OR CREMATORY		22c. LOCATION	
SPECIFY Burial		Asbury Cemetery		CITY OR TOWN COUNTY STATE	
22d. DATE		22e. DATE REC'D. BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
May 9, 1986		MAY 15 1986		Lee A. Patterson & Son, Perryville, Md.	

00-07819

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 4 7 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>John E. Tolbert</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 22, 1986</i>		2b. HOUR M <i>M</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 10, 1921</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS <i>65</i>		8. UNDER 24 HRS HOURS MIN. <i>65</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.						
10. CITY OR TOWN OF DEATH <i>Port Deposit</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>274 Dr. Jack Road</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Driver</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>V.A.M.C.</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland</i>		13b. COUNTY <i>Cecil</i>		
13c. CITY OR TOWN <i>Port Deposit</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>274 Dr. Jack Road 21904</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Oliver Tolbert</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Frye</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF KNOWN) <i>223-26-3533</i>		17. INFORMANT ADDRESS <i>Pearl V. Tolbert, Port Deposit, Maryland</i>		
18. CAUSE OF DEATH (Enter only one cause per line for Part I, and only one for Part II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SHOCK</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMATOSIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <i>BOWEL CARCINOMA</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>NO</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22. I certify that (I) (this hospital) attended the deceased from <i>1970</i> to <i>May 22, 1986</i> , that (I) (we) last saw the deceased alive on <i>May 19, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22a. SIGNATURE <i>Dante Monakil</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>5/22/86</i>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dante Monakil M.D.</i>		22e. ADDRESS <i>622 S. Union Ave., Havre de Grace, Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 26, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Rose Cemetery</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS <i>Lee A. Patterson & Son, Perryville, Maryland.</i>				
25a. DATE REC'D. BY REGISTRAR <i>MAY 28 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson - Spindel</i>				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-07004

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AMOS TRIMBLE			2a. DATE OF DEATH MONTH DAY YEAR 4 26 86			2b. HOUR 11:55 PM			
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 24 1892		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cecil		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General - Marley Mills		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Bridge & High Streets, 21921	
14. FATHER'S NAME FIRST MIDDLE LAST William Trimble				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Jane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-07-2637		17. INFORMANT ADDRESS Mildred Long Rt. 5 Madisonville, Tenn.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/23/86 , 19____, to 4/26/86 , 19____, that (I) (we) last saw the deceased alive on 4/26/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jayantical K. Patel MD DEGREE						22c. DATE SIGNED 4/28/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTICAL K PATEL MD				22e. ADDRESS 123 Singlerly Ave, Elkton MD 21921					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4-30-86		23c. NAME OF CEMETERY OR CREMATORY R. A. Ferris Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester, Pa.			
24. FUNERAL DIRECTOR NAME Gee Funeral Home, P.A.				25a. DATE RECD. BY REGISTRAR MAY 01 1986		25b. REGISTRAR'S SIGNATURE John L. ...			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page prior to burial, cremation, or other final disposition with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked "X", item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

00-06051

STATE OF MARYLAND											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO. 8614473											
1. DECEASED NAME (TYPE OR PRINT) STRATTON L. VAN BUREN					2a. DATE OF DEATH MONTH DAY YEAR May 2, 1986			2b. HOUR 12:08pm			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR March 3, 1948		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 312 Stevens Circle, Apt. 3B					13f. STREET ADDRESS / ZIP CODE 21001						
14. FATHER'S NAME FIRST MIDDLE LAST Stratton L. VanBuren Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Major						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 10/24/79-1/24/86					16b. SOCIAL SECURITY NO. 183-40-1596		17. INFORMANT ADDRESS Hempstead, NY 11550 Burnett Funeral Home 456 S. Franklin Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Probable pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Acquired Immune Deficiency Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HTLV 3 Encephalopathy											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) xxxx examined the deceased from February 20, 1986 to May 2, 1986 xxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If we (we did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>						DEGREE		22c. DATE SIGNED 5/2/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LONERGAN, M.D.						22e. ADDRESS VA Medical Center, Perry Point, Md.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May, 7, 1986		23c. NAME OF CEMETERY OR CREMATORY Calverton Nat. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Calverton Suffolk New York			
24. FUNERAL DIRECTOR <i>[Signature]</i> Patterson & Son, Perryville, MD						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

050823

DAVID WILKINSON



00-06010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 7 4
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WARD M. WHITTUM			2a. DATE OF DEATH MONTH DAY YEAR May 5, 1986		2b. HOUR 6 A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 6, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5 Woods Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouse Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Purchasing
13a. STATE Maryland			13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William H. Whittum			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen B. Maxim		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 006 26 2141		17. INFORMANT ADDRESS Md. Edith T. Whittum 5 Woods Rd., Elkton	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 4-3 19 86 to 4-9 19 86 , that (I) (we) last saw the deceased alive on 4-9 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Yogish A. Patel		DEGREE MD		22c. DATE SIGNED 5/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish A. Patel MD		22e. ADDRESS 1700 Shallcross Ave., Wilmington, Del.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 6, 1986		23c. NAME OF CEMETERY OR CREMATORY Silverbrook	
24. FUNERAL DIRECTOR NAME Robert J. Jones		ADDRESS Wilmington, Del.		25a. DATE FACED BY REGISTRAR MAY 8 1986	
25b. REGISTRAR'S SIGNATURE John H. Jones					

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

